Budget 2016: Time to focus on "what's next"

Health
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Health was a long way from the headlines in 2016's budget. One reason was that the vast majority of what was included had been announced well before budget night. Another is the upcoming election – healthcare controversy can be politically painful. In many respects, the budget could be seen as a holding pattern for the next government to take up the next reform priorities. Based upon statements in this year's budget, our analysis this year focusses on some areas where there is a path forward, progress made with more to do, and considers some questions for the future.

A path forward: hospital funding

This year's budget included the funding for COAG's hospital agreement with the States and Territories, which provides up to $2.9bn of additional funds on the basis of Activity Based Funding (ABF) from 1 July 2017. On top of this, although not as prominent – the Commonwealth increased its planned contribution to hospital funding for 2016-17 by $700m. This agreement addresses one of the most controversial aspects of the 2014 budget, whereby ABF was to be abandoned for funding linked to CPI and population growth. The recommitment to ABF has the advantage of re-instating the shared incentive between Governments for managing increased volume of care. However the Commonwealth's recommitment to ABF is different to the situation pre-2014, with agreement to fund only 45% of the cost of efficient growth, and its total funding growth is agreed to not exceed 6.5% per year.

Underneath this agreement are a number of very interesting details that will influence hospital funding in years to come. First, it is possible that the Commonwealth funding will not actually meet this cap, with States having a strong incentive not to allow this growth. Whilst agreement has not been reached with States and Territories as to how the cap will operate, recent trends indicate that 6.5% growth may not occur. This seems to have been anticipated by some – there is a provision in the agreement that if a state would receive less money than they would have received on the basis of CPI and population growth, the Commonwealth will consider if there is a case for additional funding to be made available. Further, every time an additional service is provided, the States and Territories have to find the other 55% of the efficient price (and more if, as is the case in some parts of Australia, the local hospitals cannot deliver to the national efficient price).

Secondly, it has been agreed to create a way in which quality and safety will be incorporated into hospital pricing and funding. Keen observers will recall the recent private health insurance controversy about not paying for certain clinical events. This agreement sets the public sector on a pathway for adjustments being made to payments in circumstances such as hospital acquired conditions and avoidable readmissions, as well as not paying for sentinel events (or 'never events'). For a long time, a criticism of hospital funding is that it pays for activity, whether this activity is reasonable or not. We have now started on the journey of adjusting funding where activity demonstrably should not have occurred, and through this also making some progress towards better incentivising connection across care settings.

It is PwC's view, however, that a lot more needs to be done to establish the right incentives for better connection across the health care system, and better support care being delivered outside hospital wherever possible. This budget does include funding for a significant step, an initiative that involves more money than the headlines would indicate. This is Health Care Homes.

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A preview of the future? Health Care Home

In our commentary on 2015's budget, PwC noted that addressing continuity of care, making sure that as patients move between service providers that they are well managed, was one of the opportunities to support more sustainable healthcare in the future. The Commonwealth's Health Care Home initiative, initially involving $21.3 million (over 2 years) to facilitate the design, operation and evaluation of trials for a new model of chronic care, on face value seems like a minor step forward: particularly in the context of the $89.5bn the Commonwealth spends across the health portfolio. It is important to note, however, that this is in addition to 'cashing out' the Medicare items that would otherwise be used to assist the 65,000 patients that will be targeted. It also seems that Health Care Homes may end up forming the foundation for major change. This is specifically flagged in the agreement reached at COAG. Here, States commit to working with the Commonwealth on the trials, and then agreed to the following:

"The results [of the trials] will be comprehensively evaluated and brought back to COAG … in 2018 for further consideration of a joint national approach to enhanced care coordination for patients with chronic and complex conditions, which may include collaborative, joint or pooled funding arrangements."

Today, Australia's health care system often fails to effectively help those who are managing a chronic or complex condition. In many cases, we waste time, energy and resources on healthcare that could have been avoided. There is significant potential that Health Care Homes, a concept that has some track record of making a difference in other parts of the world, could form the foundation for new national funding arrangements that break down the boundaries between "State" and "Commonwealth" responsibilities.

Beyond Health Care Home, can we do more to tackle waste or poorly directed funds?

This budget says yes. It commits $66.2m over four years to Medicare compliance measures to "better detect fraud, abuse, waste and errors", and flags that the Medicare Benefits Schedule Review Taskforce has started to identify savings from out-of-date Medicare items. It is PwC's view that one of the issues that should always be at the front of the agenda is whether healthcare spending is appropriate and not wasteful. Where money is being spent on healthcare, it should be spent wisely and well. In the context of what Australians spend on healthcare, there is much more that can be done. Whilst it has not received as much attention, recent evidence on the variability in clinical practice, often linked to the location of patients and their healthcare specialists, indicates that there is real potential to do more on ensuring that services are appropriate. Over-servicing places pressure on both the public system (through Medicare) and private system (through private health insurance premiums). The Government's responses, both in this and previous budgets, raises some questions that may still need to be addressed by the new Government.

Having said that, two significant announcements in this budget were focussed upon areas where the government felt funding could be better directed:

- A Child and Adult Public Dental Scheme. Here the government is replacing a range of funding arrangements with a scheme that is centred upon on those who, on face value, would be less likely to access dental care – children and concession card holders.
- Changes to the Aged Care Funding Instrument (ACFI). In aged care, it is an expected long-term trend that a higher proportion of residents will have complex conditions to manage – we are getting better at supporting older Australians in the community where they do not have highly complex needs. The Government has identified, however, areas where claiming is above their expectations, and have adjusted funding calculations. We expect funding arrangements for aged care will continue to be analysed and adjusted in future, balancing the costs to government with the need to support a sustainable aged care sector.

Are we at risk of asking consumers to contribute too much?

In seeking to manage the growth of Medicare spending, the Government has continued a pause on indexation of Medicare rebates, saving almost $1bn across the forward estimates. Whilst the Government has flagged new bundled and incentive models for GPs treating chronically ill patients are part of the way that it will be seeking to address concerns that Medicare fees are not keeping up with the cost of care, the AMA has been vocal in criticising the changes:

***"The only way that GPs can maintain their services is to start to charge patients. While there has not been a significant change in bulk billing rates, GPs have absorbed [the rebate freeze], they've absorbed it for a period of time."* – Brian Owler, AMA President**

A risk identified by the AMA is that GPs will either start charging fees (by stopping bulk billing) or increase their existing fees, discouraging patients from seeking care when it is needed. There is a poorly understood component of our healthcare system that provides some foundation for concern about the burden placed on healthcare consumers to pay for their care. According to the OECD, Australians pay more than the OECD average in out-of-pocket healthcare costs, and significantly more than countries such as the UK, New Zealand and Canada. Further, the level of out-of-pocket spending has increased in recent years to around 20% of the total of all healthcare spending. Whilst increasing spending by consumers of healthcare is often evidence of a wealthy society where individuals have the means to invest in their own health, it will be challenging to ensure that with continued freezes in rebates we do not have a situation where those who struggle to pay are choosing not to access healthcare.

What should we do with private health insurance?

One of the ways in which Australia seeks to provide consumer choice, and reduce pressure on the public system, is through support of the private health insurance sector. It also, however, is under pressure. The Government has recognised this, undertaking its own consultations on the value and long-term sustainability of private health insurance given the impact of factors such as the growth of chronic disease, increasing cost, and the ageing population.

2016's budget did not include measures in response to this consultation. It is PwC's view that of all the sectors of the healthcare system, private health insurance is the one where there is clearest evidence of the need for significant reform, addressing factors such as:

- The fact that private health insurance costs have continued with annual price increases of 5-6%, significantly exceeding the annual cost growth per service in the public health system under ABF (just over 1%).
- The lack of transparency on healthcare outcomes that could help consumers to make more informed choices on how to use their private health insurance, including their out-of-pocket expenses and the experience of other patients.
- The reduced impact, over time, of the private health insurance rebate which no longer linked to the full increase of the premium cost.
- Whether or not the right incentives are in place for consumers to keep themselves well, and not claim on their insurance.
- The significant gap between what Medicare and insurers will cover, and the full cost of hospital treatment.
- Whether the Commonwealth rebate for all aspects of private health insurance, such as extras beyond dental, delivers healthcare outcomes that are worthwhile for the level of spending that is made.
- The ability for insurers to adjust payments for quality and safety outcomes.

And finally, sin taxes?

Arguably the biggest healthcare announcement was not made in the health portfolio. The budget increased tobacco excise, with expectations that this will raise $4.7bn over the next four years. From a healthcare perspective, it would be tremendous if the government never received this revenue – it is dependent upon people buying cigarettes, so if there is reduced smoking, less revenue! Australia's smoking rate has almost halved since 1980 to 13.3% of the Australian adult population. Should this reduce to zero, it seems that this would reduce Commonwealth revenue by at least $10bn. Given the opportunity to save many thousands of lives, and avoid tens of billions of dollars of economic and healthcare costs, this is one time where we can hope that Treasury projections of additional revenue prove to be too high.

In addition to tobacco strategies, the Government did announce continued funding for the Health Star Rating system. There was little else, however, focussed on prevention of the diseases that are increasingly utilising Australia's healthcare resources. One area of significant concern is obesity – a recent report developed by PwC with Obesity Australia flagged the scale of the challenge that Australia faces, and the need to urgently embrace interventions that could arrest the growth rate of obesity.

There is no doubt that one of the challenges facing government is finding prevention strategies that work. Whilst it is tempting to point out a lack of evidence that something will definitely work, the challenge of encouraging Australians to change their behaviour is such that new ideas need to be tested and adopted. Some governments around the world are seeing a 'sugar tax' as one strategy that could help – most recently the UK. It does remain unclear whether a 'sugar tax' would lead to healthcare benefits. Whether a tax could of itself have an impact in lowering consumption is hotly debated. What is less controversial is the link between consumption of sugary drinks and an increase in the risk of type 2 diabetes, heart disease, and other chronic conditions.

Just as it is reasonable to see that it was not simply tax but the suite of actions taken around smoking (for example education campaigns, workplace changes, public place smoking restrictions, plain packaging) that had a dramatic impact on our health, a suite of actions need to be our response to preventable chronic disease. Whatever the choices taken by the next Australian government, identifying and using policy levers that discourage people from behaviour that can harm health, and conversely make choices that help their health, can and should be a top priority for policy development.

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